OCEAN WAVE MEDICAL
87 Bowman Road, Caloundra
Ph: 07 5491 9044 Fax: 07 5491 8068
Email: info@oceanwavemedical.com.au

REQUEST FOR TRANSFER OF MEDICAL RECORDS

Date: __/__/__

Dear Doctor_____

Address:_____

Phone:_____ Fax:_____

The following patient/s is now attending our practice; it would be appreciated if you could forward a copy of their medical records at your earliest convenience.

PATIENT NAME:_____ DOB:__/__/__

I give permission for the release of my/our medical records to the above practice.

Signed:_____ (anyone over 16yrs must sign)

Other family members:	DOB	Signature of Parent/Guardian
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Could you please advise if/when the following have been completed.

GPMP & TCA (721, 723) Date:__/__/__
Mental Health Care Plan (2710, 2712) Date:__/__/__
Any type of Health Assessment Date:__/__/__

NEW GENERAL PRACTITIONER AT OCEAN WAVE MEDICAL, CALOUNDRA

IS:_____